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| **APPLICATION CHECKLIST** | | | |
|  | Application – Completed, as directed in black ink |  | Dental Referral Form |
|  | Contract – Read and signed by parent(s) and applicant |  | Report Card |
|  | Applicant Questionnaire – Handwritten by the applicant |  |  |
|  | Household Information – Complete and accurate |  |  |
|  | 2 Letters Of Recommendation – Letters from at least two community leaders or teachers, with contact information attached | | |
|  | 2 Photos – Close up photos of applicant’s teeth while smiling. (1) photo, teeth showing from the front and (1) photo of the teeth from the side. | | |

**IT IS YOUR RESPONSIBILITY TO ENSURE ALL DOCUMENTS ARE INCLUDED. WE WILL NOT NOTIFY YOU IF YOUR PACKET IS INCOMPLETE!**

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| --- |
| **ORTHODONTIC SCHOLARSHIP** |
| Smile for a Lifetime (S4L) is an international program that provides orthodontic scholarships (free braces) to children ages 11-17 who normally would not be |
| able to afford treatment. Dr. Mattiacio has formed a local chapter to serve children in Farmington, NY. There is no cost to those chosen |
| to receive an S4L orthodontic scholarship. |
|  |
| Scholars are chosen by a local board of directors and the process is competitive. **Scholarships are limited** and based on financial need, orthodontic need, and |
| a complete and accurate application. |
| **QUALIFICATIONS** |
| * Applicant must reside in Yates, Seneca or Livingston counties of New York. |
| * Family income of no more than (185%) of the federal poverty level. (Income eligibility form attached)\* |
| **If** **Chosen**, proof of income will be **required** to verify eligibility prior to treatment. W-2, Income tax return, SSI award letter, TANF grant letter etc. |
| * Applicant must be between the ages of 11 – 18. |
| * Have “good” dental hygiene practices and had a dental hygiene check-up in the past 6 months. |
| * Must have a functional and/or aesthetic need for braces. |
| * Must currently be enrolled in school. |
| * Must demonstrate a positive attitude. |
| * Must follow and abide by treatment plan set forth by the orthodontist and contract attached. |
| * Should demonstrate a willingness to get involved in the community through extracurricular activities and/or volunteer service. |
| * Must have positive letters of recommendation from at least two community leaders and/or teachers. |
| **\* Chapter may consider exceptions under the “special circumstances” clause. Please speak with an S4L representative for more information** |
| **NOTE: If awarded, Proof of income is required prior to treatment. i.e. W-2, Income Tax Return for previous year, SSI Award Letter, Child Support, TANF grant letter, etc.** |
| **APPROVAL PROCESS** |
| * The screening committee for the Mattiacio Orthodontics of Smile for a Lifetime will select applicants on an ongoing basis. |
|  |
| * Selection is based on the information provided within this packet (i.e. commentary, personal essay, character, and accompanying letters of recommendation), |
| orthodontic and financial need. |
|  |
| * Please ensure that the packet is filled out completely and accurately. Incomplete packets will not be submitted to review board for selection process. |
|  |
| * If you would like to reapply, please speak with an S4L representative for further information. |

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| |  |  | | --- | --- | | **ORTHODONTIC SCHOLARSHIP APPLICATION FORM** | | | Today’s Date: | Primary Dentist: |  APPLICANT INFORMATION  |  |  |  |  |  | | --- | --- | --- | --- | --- | | Applicant’s Last Name: |  | First: |  | Middle: |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | Applicant’s Date Of Birth (MM/DD/YYYY): | | | |  | | | | | | | Applicant’s Age: | | |  | | | | | | Applicant’s Gender: | | | | | | MALE | FEMALE | | | Are you currently enrolled in school: | | | | YES | | | NO | | What grade are you in : | | | | |  | | | | | | What is your GPA: | | | |  | | | | | | Name of School: | | | | Address (City, State, Zip Code): | | | | | | | | | | | | | | | | Phone Number: | | ( ) | | | | | | | |  | | | |  | | | | | | | | | | | | | | | | Fax: | | ( ) | | | | | | | | Are you wearing braces? | | | If you are over the age of 16, what are your plans over the next 3 years (Moving, College, etc.): | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Home Address: | | | | City: | | | | | | | | State: | Zip: | | | | Home phone no.: | | | | | | Cell phone no.: | | | | | | |  | | | |  | | | | | | | |  |  | | | | ( ) | | | | | | ( ) | | | | | | | How did you hear about Smile for a Lifetime (please circle or write in your answer)? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Internet Search | | Family | | | Friend | | | | | Dentist/Orthodontist | | | | | Boys & Girls Club | | | | | | State Office | | | | Other:  **(Please Specify)** | | | | | Television | | Magazine | | | Radio | | | | | Newspaper | | | | | CASA | | | | | | Internet Ad | | | |  | | | | | Are you a member of any of the following organizations? Circle all that apply: | | | | | | | | | | | | | | | | BBBS | | | | | BGCA | | | | CASA | | | NCOHF | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **There are many reasons why people get braces; please select the following that apply or feel free to add your own:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | Discomfort while eating/drinking | | | | |  | | Jaw and/or mouth pain | | | | | | | | | |  | I look down when talking | | | | | | | | | | |  | Speech Impediment | | | | |  | | I get teased about my teeth | | | | | | | | | |  | I cover my mouth when I laugh | | | | | | | | | | |  | It’s hard to clean my teeth well | | | | |  | | I’m embarrassed to smile | | | | | | | | | |  | I have a hard time sleeping/Sleep apnea | | | | | | | | | |   **GUARDIAN INFORMATION**   |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | Guardian’s Name: | Guardian’s Occupation: | | | | Guardian’s Employer: | | | | | Employer phone no.: | |  |  | | | |  | | | | | ( ) | | Guardian’s Name: | Guardian’s Occupation: | | | | Guardian’s Employer: | | | | | Employer phone no.: | |  |  | | | |  | | | | | ( ) | | Have any other children in the household been treated through Smile for A Lifetime (If so, whom)? | | | | | | | | | | | |  | | | | | | | | | | | | Please explain in detail why you would like your son or daughter to be awarded an orthodontic scholarship through Smile for a Lifetime. | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | | What is the best way to reach you?: |  | Phone: ( ) | | | |  | Email: | | | | | **APPLICANT QUESTIONNAIRE** | | | | | | | | | | | | **HANDWRITTEN BY THE APPLICANT ONLY. Each question must be answered in essay format 5 to 7 sentences in length.\*** | | | | | | | | | | | | Tell us about yourself. What do you like to do? Favorite hobbies, extracurricular activities, and the types of goals and aspirations in life. etc. | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | | Tell us about your family. How many siblings do you have, who are they, do they live with you, what do you like to do together? etc. | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | | Please tell us, in detail, why you would like braces and/or orthodontic treatment and how will orthodontia change your life? Etc. | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | | If you had a chance to do a favor for another person/organization, without any expectation of being paid back, what would you do and why? | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | | **\*If the minimum requirements are not met, your application will be considered incomplete and not included in selection process.** | | | | | | | | | | | | **CONTRACT** | | | | | | | | | | | | **If** selected from the pool of applicants by the screening committee of Smile for a Lifetime Mattiacio Orthodontics to receive orthodontic | | | | | | | | | | | | treatment, there are a few guidelines required for treatment. Throughout the selection process there is some professional guidance provided, if requested, but the | | | | | | | | | | | | decision is largely subjective and based on the completeness of the application, commentary, personal essay, character and the accompanying letters of reccomenda- | | | | | | | | | | | | tion submitted with your packet. Orthodontic treatment for Mattiacio Orthodontics Chapter of Smile for a Lifetime will be provided by Dr. Mattiacio and the | | | | | | | | | | | | team in his office . | | | | | | | | | | | | **By submitting and signing this application you understand and agree to the following:** | | | | | | | | | | | | 1. I agree that appointments will be at the discretion Dr. Mattiacio and his team. | | | | | | | | | | | | 1. I understand that this can mean scheduling appointments during non-peak hours. | | | | | | | | | | | | 1. I acknowledge that appointments must be kept in order to achieve an expeditious and desirable result. | | | | | | | | | | | | 1. I also understand that keeping appointments is essential to treatment success and is a requirement of accepting care from Dr. Mattiacio. | | | | | | | | | | | | 1. If you must reschedule appointments, give the practice at least 24 hours’ notice. If more than two appointments are missed or appointments are | | | | | | | | | | | | constantly rescheduled it will be considered out of compliance which is grounds for removal of braces and revocation of scholarship. | | | | | | | | | | | | 6) If you *must* relocate prior to the conclusion of treatment, Smile for a Lifetime will do its best to find another service provider. However, it is not | | | | | | | | | | | | guaranteed that Smile for a Lifetime will have another provider available in the area and/or can continue to provide treatment as a result. | | | | | | | | | | | | 1. One retainer will be provided as a part of the scholarship award, any replacements will not be covered by or Smile for a Lifetime or Mattiacio Orthodontics | | | | | | | | | | | | Chapter of Smile for a Lifetime. | | | | | | | | | | | | 1. **Direct responsibilities of the patient:** | | | | | | | | | | | | |  |  | | --- | --- | | 1. Maintain excellent oral hygiene (tooth brushing, flossing). If unwilling to meet expectations due to medical and dental health risks, treatment will be discontinued. | | | 1. Follow the rules for eating habits. This will greatly reduce breakage of appliances (i.e. braces) and it is necessary for satisfactory completion of treatment. | | | 1. Cooperate. More than two (2) loose brackets may be deemed sufficient evidence that cooperation is not sufficient to meet minimal requirements for treatment. | | | d) Other cooperation issues are with failure to cooperate with maintenance of auxiliaries including elastics, wearing head gear, and springs. | | | 1. Attitude. You will be expected to maintain an exceptionally appreciative and respectful attitude once accepted into orthodontic treatment or any other aspect of treatment | | | supported by Dr. Mattiacio or Smile for a Lifetime. Rude behavior or an inappreciative attitude is unacceptable. | | | 1. **ATTENTION:** Failure to fulfill your responsibilities may result in removal of orthodontic equipment and discontinuation of treatment | **Applicant Initials: ­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | 1. **ATTENTION:** Honesty is expected. Any misrepresentation, falsification or exclusion of income will be grounds for dismissal from the program. Future applications | | | | | | | | | | | | | | |  |  | | --- | --- | | will not be considered. There are many deserving children who are in need of orthodontics, we are here to serve those in greatest need. | **Guardian’s Initials**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | 1. **Media Disclaimer**: If your child is the chosen applicant, you consent to Smile for a Lifetime’s (S4L) use, without charge, of all photos, video and audio recordings of your child. S4L may, | | | 1. Copyright, broadcast, display, publish, re-publish and reproduce your child’s image, voice and any statements made by him/her, in whole or in part, in any and all media forms; and | | | 1. Assign your child a fictitious name or use his/her first name, likeness, video, photograph, voice, statements and biographic or other information concerning his/her participation with | | | S4L for fundraising or other promotional and advertising purposes. You and your child also agree to participate in surveys and case management during and after receiving treatment. | | | | | | | | | | | | | | **Legal Guardian Consent:** I certify that I am the legal guardian of the child listed on this application. I have all rights and authority to make medical decisions for the child, that all information | | | | | | | | | | | | in this application is true and correct. | | | | | | | | | | | | **This scholarship is intended specifically for underserved and deserving children in the community. There are many children who need and deserve an** | | | | | | | | | | | | **award winning smile and while we do our best to serve those greatest in need, it is a competitive process and not everyone will receive a scholarship.** | | | | | | | | | | | | **Please take your time on your application; your time and effort will be taken into consideration when selecting applicants for scholarships.** | | | | | | | | | | | |  | | |  |  | | | |  |  | | |  | | |  |  | | | |  |  | | | Applicant’s Name (Printed First, MI, Last) | | |  | Applicant’s Signature | | | |  | Date | | |  | | |  |  | | | |  |  | | | Guardian’s Name (Printed First, MI, Last) | | |  | Guardian’s Signature | | | |  | Date | | |  | | |  |  | | | |  |  | | | Guardian’s Name (Printed First, MI, Last) | | |  | Guardian’s Signature | | | |  | Date | | |